ISSN: 2321 – 7537
IJEDST (2013), 1(1):36-39

Depression and Behavior problem in School-going Children

Dr. R. Kannappan, Ph.D., D.Litt.,
Reader in Clinical Psychology, Department of Psychiatry, Vinayaka Mission Medical College, Salem 636308 INDIA
kannappanlaks@gmail.com

Abstract:
Background: School children evidence depression and behavior problem in one or more settings such as home, school etc. These problems lead to students' social or academic and functional impairment in all areas of psychosocial world. The purpose of the study was to measure depression and problem behavior of school children and to assess gender differences.
Design: Cross sectional survey was used to measure depression and behavior problem of the school children by using suitable psychological scales.
Sample: Two groups of male and female students served as sample of the study. Each group consisted of 45 boys and 45 girls who came for treatment to the hospital. Depression scale and children's behavior questionnaire were administered to the two groups of children and demographic variables such as age, religion, income, education, and occupation were collected from the children. Percentage, correlation, and t - test were used for analyzing and interpreting the obtained data.
Results: Results indicated that the groups of depressed male and female children had significant correlation between depression and behavior problem. Moreover each group had a significant correlation between depression and emotional problems as well as behavioral problems. The groups of male and female children did not differ significantly in depression but they differed in emotional and behavioral problems.
Conclusion: The groups of male and female children had positive correlation between depression and behavior problem. They had no significant difference in depression but they had significant gender differences in behavior problem. They too had gender differences significantly in emotional and behavioral problems. The present findings of emotional and behavior problems could help the planners to develop strategy/ intervention to reduce depression and emotional and behavioral problems for better coping with.

Key words: Depression, behavior problem and school children

INTRODUCTION

School children with depression may experience negative outcome such as lowered self-esteem, withdrawal, lack of concentration, poor academic performance, and increased risk of anxiety, and suicidal tendency, etc. The children with depressive disorder manifest masked symptoms through externalized behavior such as aggression, hyperactivity, and social problem with peer. The children who are depressed tend to avoid social interactions and often face feelings of worthlessness. They tend to be socially withdrawn and have minimal conversational skills, no friends and longstanding socially isolated life style [1 & 2]. Their peers do not accept depressed children as non-depressed children [3].

Estimates of the prevalence of depression in children and adolescents range from 2% to 44% [4]. The child's depressive symptoms must produce social or academic and functional impairment in all areas of a child's psychosocial world, school performance, behavior, and peer and family relationships. In the functional impairment, children manifest various behavioral changes in interpersonal and academic levels. Their school marks may drop, their concentration may deteriorate, homework might not be done, they might increasingly be absent from school and they may lose interest in hobbies or sport. It then becomes essential for educators to have an understanding of what these symptoms are and ways to help these children [5].

Beside, Children who exhibit problem behavior at school are likely to struggle in their studies early and have problems throughout school career [6; 7; & 8]. The problems affect children's physical health, and their feeling, thinking, and acting toward others. Children's behavioral and emotional symptoms have two main divisions of externalizing and internalizing symptoms. The externalizing means to deregulation of behavior and internalizing refers to problems in regulating emotions and mood. This classification has been adopted in many studies and this gives a useful way to systematize the spectrum and prevalence of psychiatric symptoms and disorders, and their antecedents [9]. Estimation of the prevalence of these disorders in different countries varies widely from 3% to 39% [10 & 11]. Further, psychopathology in term of severity and association with impairment of functioning in 6–19% of children and adolescents has been identified from the studies of different parts of the world [12; 13; &14].

Children's problems such as inattention, calling out, disturbing others and non-compliance at school are a somewhat different spectrum compared with home [15; & 16], and teachers can provide unique information to evaluate the severity of children's psychopathology [17]. (Verhulst & van der Ende, 1997). Any behavior that significantly interferes with the child's own learning, other children's learning or responses, [18] requires an effective management of the problems as an imperative duty for mental health professional and teachers. The teachers can focus on the problem behavior and observe their daily functioning. It has become apparent that teachers are important informants on their functioning and behavior outside the parental home after entering into school [19 & 20].

ISSN: 2321 – 7537
IJEDST (2013), 1(1):36-39

The teachers can be more sensitive than parents to internalizing (anxiety and depressive) symptoms in children [21] and they can be a valuable source of information on changes in school performance. The present study attempts to assess the relation between depression and behavior problems of children and gender difference in depression and behavior problems who have come for treatment to the Vinayaka Missions Hospital, Salem, INDIA

OBJECTIVES

They were

a) to use appropriate scales to measure depression and behavior problems of school children.

b) to find out the relationship between depression and problematic behavior, and

c) to compare the groups of male and female children for gender differences in depression and problematic behavior.

METHOD

Design: Cross section survey design was used for the study. The school children who had depressive features for more than a month came to the hospital for treatment to their problems.

Sample:

The groups consisted of 45 boys and 45 girls who came to Vinayaka mission hospital for treatment. They had the symptoms of depression such as irritable mood, diminished interest in studies etc. They were in the age of 9-12 years, and were studying 5th and 6th standards in different schools. They belonged to Hindu, Muslim, and Christian religions. Depression scale was administered to the male and the female children and they were requested to fill up the behavior questionnaire by their teachers. The collected questionnaires, each group consisted of 45, were used for analysis for the study.

Measures:

Children Depression Rating Scale (CDRS), developed by Ponznanski and Cook (1960) was a 16 item scale used to evaluate the severity of depression in children in the age of 6 to 12 years. Each items was rated on either a 0-3 spectrum (0=no information and 3= most severe) except the last item which was answered by a yes or no. The total score of the CDRS consists of the sum of the items [22 & 23].

The Rutter's children's behavior questionnaire:

The questionnaire for completion by teachers had 26 items concerning child's behavior at school and the teacher was asked to indicate on either zero to three scale (0= does not apply, 1= applies somewhat, 2= certainly applies) or zero to five scale (0- no information, 5 most severe) except last item which was a reversal of affect, answered by a yes or no. The scores ranged from 0-52. In this questionnaire, 11 items cover bullying, disobedient, aggressiveness, lying, irritable, destroying, restless, squirmy, unconcentrated and violent), and 15 items were disliked, fussy, anxious, painful, nail biting, solitary, unhappy, apathetic, tearful, truant, tics, stuttering, absent, worried and sucking.

Statistics such as percentage and t-test were calculated for analyzing the obtained data.

Table 1: Demographic variables of the boys and girls.

Variables	Groups	Boys		Girls	
		N	%	N	%
Age	9-10 years	24	53.3	26	57.8
	11-12 years	21	46.7	19	42.2
Education	5th standard	22	48.9	28	62.2
	6th standard	23	51.1	17	37.8
Religion	Hindu	36	80	33	73.3
	Christian	5	11.1	7	15.6
	Muslim	4	8.9	5	11.1
Father's education	No formal education	6	13.3	5	11.1
	< 8th standard	14	31.1	11	24.4
	< 10th standard	13	28.9	14	31.1
	.>10th standard	12	26.7	15	33.4

Table 2: Correlation of depression and behavior problem of the children

S.No	Scale	Questionnaire	Group	r	Group	R
1	Depression	Behavior (total)	boys	.323*	girls	.546*
2a	Depression	Behavioral problems	boys	.379*	Girls	.97*
2b	Depression	Emotional problems	Boys	.58*	Girls	.362*

*$p < .01$.

ISSN: 2321 – 7537
IJEDST (2013), 1(1):36-39

Table 3: Mean, Standard deviation, and t-value for the scores of the children's depression and problematic behavior

S.No	Scales	Groups	N	X	SD	t- value
1	Depression	boys	45	28.56	3.91	
		girls	45	28.49	3.82	0.46
2	Behavior questionnaire					
	a. Behavioral problems	boys	45	12.20	1.60	
		girls	45	11.31	1.28	2.98*
	b.Emotional problems	boys	45	23.98	5.11	
		girls	45	20.47	4.50	3.35*
	Total score	boys	45	37.76	4.94	
		girls	45	34.44	3.72	3.78*

X- Mean; SD- standard deviation; Significance: *p < 0.01.

RESULTS

Majority of the boys and girls as indicated in Table 1 belonged to the age group of 9-10 years (53.3%) & (57.8.3%), followed by the age group of 11-12 years(46.7%) & 42.2%), and belonged to Hindu (80%) & (73%), followed by Christian (11.1%) & (15.63%), respectively. Majority of boys were doing 6th standard (51.1%) & girls were doing 5th standard (62.22%). Majority of the boys' fathers had education less 8th standard (31.13.3%), followed by < than 10th standard (28.9%). Girls' fathers had education above 10th standard (37.5%), followed by < than 10th standard (31.1%).

Table 2 showed that there is significant correlation between depression and behavior problems both in boys and girls. The two divisions of behavior problem have positive correction with depression. This indicates that depression would lead to the behavior problems in male and female school children.

Mean and standard deviation were calculated for the two groups of sample (males and females) to compare the significant difference between the male and female students as indicated in Table 3. t- test was applied to determine the significance difference between them. The male and female students did not differ in depression. This shows that the children who came for treatment have equal amount of severity in depression. The children differ significantly in behavior problem due to their depression.

DISCUSSION

This paper aimed a threefold purpose:

a) to determine the depression of male and female school children, and
b) to measure the correlation between depression and behavior problem and,
c) to determine behavioural and emotional problems in young children, as they occur in the classroom, based on their teachers report.

The present study focuses that the male and female children who reported academic and problematic behavior at school have sought treatment in the Vinayaka Missions Hospital, Salem, INDIA. They have depressive symptoms such as irritability or anger, continuous feelings of sadness and hopelessness, social withdrawal, increased sensitivity to rejection, changes in appetite-either increased or decreased, changes in sleep -sleeplessness or excessive sleep, vocal outbursts or crying, difficulty concentrating, fatigue and low energy, physical complaints (such as stomach aches, headaches) that do not respond to treatment, reduced ability to function during events and activities at home or with friends, in school, extracurricular activities, and in other hobbies or interests, feelings of worthlessness or guilt, impaired thinking or concentration, thoughts of death or suicide. They reported significantly more depressive symptoms on the Children's Depression Rating Scale.

Contrary to our expectation, the group of boys did not have statistical significance from the group of girls in the severity of depression. The small sample size of the comparison is limited to study the differences between the male and female children who have come from different schools for treatment. The second finding of this study is that there is significant, positive correlation between depression and behavior problem of the group of boys. Similarly the group of girls too have significant, positive correlation between depression and behavior problem. Moreover both the groups have significant correlation between depression and emotional problems as well as behavioral problems. These show that depression could lead to problem behavior in both sexes. Hence, the depressive disorder must be managed effectively to arrest the problem behavior in school children of both sexes.

Though the groups did not differ in depression, they did differ significantly in problem behavior. Moreover, these groups differed in emotional and behavioral problems significantly.

LIMITATION

Children with depressive symptoms who have come from different schools, Salem for treatment represent the sample of the study. They were studying in different standards.

CONCLUSION

The depressed boys and girls had no significant difference in depression. The depressed boys and girls had significant relation between depression and behavior problem. These two groups of boys and girls differed significantly in emotional as well as behavior. The present findings of emotional and behavior problem could help the planners to develop strategy/ intervention to reduce depression and problem behavior for better coping with. Schools can play an important role in screening the depressive children and preventing problem behaviors which affect their school or academic performance.

ACKNOWLEDGMENT

The authors thank the male and female students and their teachers and Vinayaka Missions Hospital, Salem, INDIA for their co-operation to fill up the scales and the time they generously spent for this study.

REFERENCES

[1] France, D.P., Cristoff, K.A., Crimmins, P.B., & Kelly, J.A. (1983) Social skills training for an extremely shy young adolescent: A case study, *Behavior Therapy*, 4, 568-575.

[2] Kannappan, R. (2009) Intervention as an Adjunct to Drug Therapy for Childhood Depressive Disorder, *Journal of the Indian Applied Psychology*, 35 (1)57-62.

[3] Faust, J, Baum, C.G, & Forehand, R. (1998) An examination of association between social relationships and depression in early adolescence, *Journal of Applied Developmental Psychology*, 6, 289-97.

[4] Son, S.E, Kirchner, J.T. (2000) Depression in children and adolescents. *Am Fam Physician*, 62(10): 2297-2308.

[5] Rice, K & McLaughlin, T.F. (2001) childhood depression: A review suggestions for special educators, *International Journal of Special Education*, 16, 84-92.

[6] Patterson, G., Reid, J., & Dishion, T. (1992). *Antisocial boy.* Eugene, OR: Castalia.

[7] Walker, H. M., Colvin, G., & Rarnsey, E. (1995). *Antisocial behavior in school: Strategies and best practices.* Pacific Grove, CA: BrookslCole

[8] Ron nelson, J, Stage, S, Duppong-hurley, K, Synhorst, L& Epsteinm. H. (2007) Risk Factors Predictive of the Problem Behavior of Children at Risk for Emotional and Behavioral Disorders, *Council for exceptional children* 73. (3), 367-379.

[9] Costello, E. J., Burns, B. J., Angold, A. & Leaf, P. J. (1993). How can epidemiology improve mental health services for children and adolescents? Journal of the American Academy of Child and Adolescent Psychiatry, 32, 1106-1113.

[10] McGee, R., Silva, P. A. & Williams, S. (1984). Behavior problems in a population of seven-year old children: prevalence, stability and types of disorder – A research report. *Journal of Child Psychology and Psychiatry*, 25, 251-259.

[11] Verhulst, F. C. (1995). The epidemiology of child and adolescent psychopathology: strengths and limitations. Em F. C. Verhulst & H. M. Koot (Orgs.). *The epidemiology of child and adolescent psychopathology*. New York: Oxford University Press.

[12] Achenbach, T. M. & Howell, C. T. (1993). Are American children's problems getting worse? A 13-year comparison. *Journal of the American Academy of Child and Adolescent Psychiatry*, 32, 1145-1154.

[13] Klein, J. M., Goncalves, A., Silva, C. F. & Peixoto, T. (2008). Problemas de Sono-vigilia em Criancas: um estudo da prevalencia. *Psico-USF*, 13(1), 51-58.

[14] Velez, C. N., Johnson, J. & Cohen, P. (1989). A longitudinal analyses of selected risk factors for childhood psychopathology. *Journal of the American Academy of Child and Adolescent Psychiatry*, 28, 861-864.

[15] Offord, D. R., Boyle, M. H. & Racine, Y. (1989). Ontario child health study: correlates of disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, 28, 856-860.

[16] Verhulst, F. C. & Akkerhuis, G. W. (1989). Agreement between parents' and teachers' ratings of behavioral/emotional problems of children aged 4-12. *Journal of Child Psychology and Psychiatry*, 30, 123-136.

[17] Verhulst, F. C. (1997). & van der Ende, J. (1997) Factors associated with child mental health service use in the community. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36, 901-909

[18] Merrett, F. & Wheldall, K. (1984). Classroom behavior problems which junior school teachers find most troublesome. *Educational Studies*, 10, 87-92.

[19] Rutter M (1967): A children's behavior questionnaire for completion by teachers: preliminary findings. Journal *Child Psychology and Psychiatry*, 8:1-11. USF, 12(2), 257-268.

[20] Kolvin I, Nicol AR, Leitch I, Macmillan A. (1977) Screening school children for high risk of emotional and educational disorders. *British Journal Psychiatry*, 131: 192-206.

[21] Puura K. (1998) Children with symptoms of depression – what do adults see? Journal *Child Psychology Psychiatry*, 39(4): 577-585.

[22] Ponznanski, E.O., Cook, S.C. & Carroll, B. J. (1979) A depression rating scale for children' *pediatrics*, 64(4) 442-50.

[23] Ponznanski, E.O., Cook, S.C. & Carroll, B. J.(1983).Use of the children's depression's depression rating scale in an inpatient psychiatric population, *Journal of clinical psychiatry*, 44 (6), 200-03.